Should this electronic version of the rules differ from the Secretary of State's official printed version, the printed version controls. These rules are posted here for convenience only until the Secretary of State posts the official version on its website. This version only includes rules that were amended or adopted in Issue 20, the October 25, 2007, edition of the Montana Register.

24.29.207 CONTESTED CASES (1) Except as provided in (2), parties having a dispute involving legal rights, duties, or privileges, where the dispute is one over which the department has jurisdiction to hold a hearing, must bring the dispute to the department for a contested case hearing.

(2) The following disputes are required to follow the administrative rules on mediation before proceeding as provided by statute to either a contested case hearing before the department or a case in the workers' compensation court:

(a) disputes over benefits available directly to a claimant under Title 39, chapter 71, MCA;

(b) disputes between an insurer and a medical service provider regarding medical services provided; and

(c) disputes involving a determination of the independent contractor central unit regarding the issue of whether a worker is an independent contractor or an employee.

(3) A contested case concerning employment classifications assigned to an employer by a Plan 2 or Plan 3 insurer is administered by the classification review committee in accordance with 33-16-1012, MCA.

(4) A contested case held by the department under Title 39, chapters 71 or 73, MCA, is administered by the department in accordance with ARM 24.2.101 and 24.29.201(2).

AUTH: 2-4-201, 39-71-203, MCA
IMP: Title 2, chapter 4, part 6, 33-16-1012, 39-71-204, 39-71-415, 39-71-704, 39-71-2401, 39-71-2905, MCA

24.29.1404 DISPUTED MEDICAL CLAIMS (1) After mediation, disputes between an insurer and a medical service provider arising over the amount of a fee for medical services are resolved by a hearing before the department upon written application of a party to the dispute or the injured worker. The following issues are considered to be disputes arising over the amount of a fee for medical services:

(a) amounts payable to medical providers, when benefits available directly to claimants are not an issue;

(b) access to medical records;

(c) timeliness of payments to medical providers; or

(d) requirements for documentation submitted by a provider to an insurer pursuant to ARM 24.29.1513 as a condition of the payment of medical fees.

(2) All other disputes arising over medical claims, including travel expense reimbursement to injured workers, shall be brought before a department mediator as provided in part 24 of the Workers' Compensation Act.

(3) Hospital records shall be furnished to the insurer upon request. Hospitals shall obtain, upon admission, the necessary release by their administrative procedures.

(4) The rule of privileged communication is waived by the injured worker seeking benefits under the Workers' Compensation or Occupational Disease acts.

AUTH: 39-71-203, MCA

Should this electronic version of the rules differ from the Secretary of State's official printed version, the printed version controls. These rules are posted here for convenience only until the Secretary of State posts the official version on its website. This version only includes rules that were amended or adopted in Issue 20, the October 25, 2007, edition of the Montana Register.

IMP: 39-71-203, 39-71-704, MCA

24.29.1426 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM APRIL 1, 1998, THROUGH DECEMBER 31, 2007 (1) Any overall rate change adopted by a hospital shall be reported to the department on a department-approved form before the effective date of the rate change. The department may in its discretion conduct audits of any hospital's financial records to determine proper reporting of rate change filings.

(2) Charges billed by a hospital are not subject to reduction under the Montana relative value fee schedule, except that hospital professional fees may be paid according to either the fee schedule or the applicable hospital rates, but not both. In the event that the department adopts a relative value fee schedule for out-patient services, this rule will be amended.

(3) Insurers shall make timely payments of hospital bills. In cases where there is no dispute over liability the insurer shall, within 30 days of receipt of a hospital's charges, either pay the charges according to the rates established by these rules, or notify the hospital that additional information is requested, and specify that information. The insurer shall then pay the charges within 30 days of receipt of the requested information.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1504 DEFINITIONS As used in this subchapter, the following definitions apply:

(1) "Current Procedural Terminology" or "CPT" codes means codes as published by the American Medical Association.

(2) "Documentation" means written information that is complete, clear, and legible, which describes the service provided and substantiates the charge for the service.

(3) "Facility" or "health care facility" has the meaning provided under 50-5-101, MCA, and the administrative rules implementing that definition, and is limited to only those facilities licensed or certified by the Department of Public Health and Human Services.

(4) "Functional status" means written information that is complete, clear, and legible, that identifies objective findings indicating the claimant's physical capabilities and provides information about the change in the status as a result of treatment.

(5) "Healthcare Common Procedure Coding System" or "HCPCS" means the identification system for health care matters developed by the federal government, and includes level one codes, known as CPT codes, and level two codes that were developed to use for supplies, procedures, or services that do not have a CPT code.

(6) "Improvement status" means written information that is complete, clear, and legible, which identifies objective medical findings of the claimant's medical status with respect to the treatment plan.

(7) "Medical equipment and supplies" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with

associated nondurable materials required for use in conjunction with the device or appliance.

(8) "Nonfacility" means any place not included in this rule's definition of "facility".

(9) "Objective medical findings" means medical evidence that is substantiated by clinical findings. Clinical findings include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not considered objective medical findings.

(10) "Physician" means those persons identified by 33-22-111 , MCA, practicing within the scope of the providers' license.

(11) "Prior authorization" means that for those matters identified by ARM 24.29.1517 the provider receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that procedure.

(12) "Provider" means any health care provider, unless the context in another rule clearly indicates otherwise. "Provider" does not include pharmacists nor does it include a supplier of medical equipment who is not a health care provider.

(13) "Relative Value Unit" or "RVU" represents a unit of measure for medical services, procedures, or supplies. RVU is used in the fee schedule formulas to calculate reimbursement fees and is expressed in numeric units. Those services that have greater costs or value have higher RVUs than those services with lower costs or value.

(14) "Resource-Based Relative Value Scale" or "RBRVS" means the publication titled "Essential RBRVS", published by Ingenix, Inc.

(15) "Treating physician" means:

(a) with respect to claims arising before July 1, 1993, the meaning provided by ARM 24.29.1511;

(b) with respect to claims arising on or after July 1, 1993, the meaning provided by 39-71-116, MCA.

(16) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. The treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities that will be employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate that treatment is to be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider in the selection of the most appropriate method of treatment; however, the treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1521 MEDICAL EQUIPMENT AND SUPPLIES FOR DATES OF SERVICE BEFORE JANUARY 1, 2008 (1) Reimbursement for medical equipment and supplies dispensed through a medical provider before January 1, 2008, is limited to a total amount that is determined by adding the cost of the item plus the freight cost plus the lesser of either $30.00 or 30 percent of the cost of the item, except prescription medicines are limited to charges allowed under 39-71-727, MCA. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(2) If a provider adds value to medical equipment or supplies (such as by complex assembly, modification, or special fabrication) then the provider may charge a reasonable fee for those services. Merely unpacking an item is not a "value-added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable.

(3) This rule does not apply to:

(a) equipment supply houses that are not also health care providers;

(b) hospitals; or

(c) pharmacies.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1532 USE OF FEE SCHEDULES FOR SERVICES PROVIDED FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) The department's schedule of fees for medical nonhospital services is known as the Montana Workers' Compensation Medical Fee Schedule. Effective July 1, 2002, to December 31, 2007, the fee schedule in this rule is hereby adopted. The fee schedule is comprised of the following:

(a) The relative value scales given in the most current edition of the Relative Values for Physicians (RVP), published by Ingenix Inc. to be used by doctors of medicine, doctors of podiatry, doctors of osteopathy, doctors of chiropractic, and practitioners licensed as occupational therapists and physical therapists for the following specialty areas:

(i) surgery;

(ii) anesthesia;

(iii) radiology;

(iv) pathology;

(v) medicine;

(vi) chiropractic;

(vii) occupational therapy; and

(viii) physical therapy.

(b) The relative unit values provided by the department in separate fee schedules developed for medical nonhospital services provided by the following health care providers:

(i) acupuncture; and

(ii) dental.

(c) The conversion factors as established by the department.

(2) Relative values have not been developed for nurse specialists, physicians assistants-certified, optometrists, psychologists, licensed social workers, or licensed professional counselors.

(3) Copies of Relative Values for Physicians are available from the publisher. Ordering information may be obtained from the department.

(4) Relative Values for Physicians uses procedure codes listed in the copyrighted publication known as Current Procedure Terminology, or CPT, published by the American Medical Association. The edition in effect at the time the medical service is furnished shall be used to determine the proper procedure code, unless a special code or description is provided by rule.

(5) Interim unit values given in Relative Values for Physicians (designated by a box and the letter "I") are included in the fee schedule and are used to calculate maximum fees payable.

(6) Unit values given in the Relative Values for Physicians section titled "HCPCS Codes" are not included in the fee schedule; services listed in this section are considered to have unit values of "RNE" (relativity not established) for purposes of maximum fee calculation.

(7) All instructions, definitions, guidelines, and other explanations given in the most current edition including updates of the RVP, affecting the determination of individual fees, except as specifically revised or deleted by the department, apply.

(8) Revisions to the conversion factors contained in the Medical Fee Schedule become effective January 1 except as otherwise provided for in these rules. An insurer is not obligated to pay more than the fee provided by the Medical Fee Schedule for a service provided within the state of Montana. The conversion factor in effect on the date the service is provided must be used to calculate the fee.

(9) The maximum fee that an insurer is required to pay for a particular procedure is computed by the unit value times the conversion factor except as otherwise provided for in these rules. Use the conversion factor approved by the department for each specialty area. For example, if the conversion factor is $5.00, and a procedure has a unit value of 3.0, the most that the insurer is required to pay the provider for that procedure is $15.00.

(10) Where a procedure is not covered by these rules, the insurer must pay a reasonable fee, not to exceed the usual and customary fee charged by the provider to non-workers' compensation patients unless the procedure is not allowed by these rules.

(11) Where a unit value is listed as "BR", it means that the fee is calculated on a "by report" basis. The fee charged is to be reasonable, and may not exceed the usual and customary fee charged by the provider to non-workers' compensation patients.

(12) It is the responsibility of the provider to use the proper procedure code(s) on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1536 CONVERSION FACTORS -- METHODOLOGY FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) This rule applies to services provided from April 1, 1993, to December 31, 2007.

(2) Except as provided by ARM 24.29.1537, conversion factors shall be established annually by the department by increasing the conversion factors from the preceding year by the percentage increase in the state's average weekly wage. If for any year the state's average weekly wage does not increase, the rates will be held at the existing level until there is a net increase in the state's average weekly wage.

(3) Beginning in 1994 the special procedure codes and descriptions may be updated by the department as necessary to maintain the most current procedural terminology. Updates may include the addition or deletion of individual procedures or the revision of individual procedure codes or descriptions.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1541 ACUPUNCTURE FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) Fees for acupuncture are payable only for the procedure codes listed in subsection (4), below, according to the unit values listed. None of the procedure codes, descriptions, or unit values in Relative Values for Physicians apply to acupuncture.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends upon the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for acupuncture specialty area services is $3.77.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) Effective April 1, 1993, through December 31, 2007, the following special procedure codes, with the associated description and unit values, are recognized for acupuncture specialty area services:

	Procedure Code	Description	Unit Value
(a)	96300	Acupuncture; initial visit and 8.0 treatment	
(b)	96301	each subsequent visit	8.0

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1551 DENTAL SPECIALTY AREA FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) Fees for dental medical specialty area services are payable only for the procedure codes

listed in subsection (4), below, according to the unit values listed. None of the procedure codes, descriptions, or unit values in Relative Values for Physicians apply to dental services.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for dental specialty area services, procedure codes D0110 through D9960 is $7.27.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) Effective April 1, 1993, through December 31, 2007, the following schedule of procedure codes, with the associated description and unit values, are recognized for the dental service areas:

Procedure Code	Description	Unit Value
(a) D0110	Initial oral examination	1.8
D0120	Periodic oral examination	2.0
D0130	Emergency oral examination	2.1
(b) D0210	Intraoral--complete series	5.2
D0220	Intraoral--periapical, first film	0.9
D0230	Intraoral--periapical, each additional film	0.7
D0272	Bitewings--two films	1.6
D0274	Bitewings--four films	2.1
(c) D0321	Other temporomandibular joint films	BR
D0330	Panoramic film	4.7
D0340	Cephalometric film	5.2
(d) D0460	Pulp vitality tests	1.4
D0470	Diagnostic casts	4.1
D0471	Diagnostic photographs	2.4
(e) D1110	Prophylaxis--adult	4.1
(f) D2140	Amalgam--one surface, permanent	4.4
D2150	Amalgam--two surfaces, permanent	4.5
D2160	Amalgam--three surf., permanent	9.4
D2161	Amalgam--four or more surf., perm.	8.2
(g) D2330	Resin--one surface	4.5
D2331	Resin--two surfaces	7.1
D2332	Resin--three surfaces	8.1
D2335	Resin--four or more surfaces or involving incisal angle	10.6
(h) D2740	Crown--porcelain/ceramic substrate	45.8
D2750	Crown--single restoration only--porcelain fused to high noble metal	42.3
D2751	Crown--single restoration only--porcelain fused to predominantly base metal	44.1

D2752 Crown--single restoration only--porcelain 45.7
fused to noble metal
D2790 Crown--full cast high noble metal 41.4
(i) D2810 Crown--3/4 cast metallic 41.1
(j) D2950 Crown build-up, including any pins 6.3
D2951 Pin retention--per tooth, in addition to 0.9 restoration
D2952 Cast post and core in addition to crown 14.8
D2954 Prefabricated post and core in addition 8.7 to crown
D2970 Temporary (fractured tooth) 5.0
(k) D3220 Therapeutic pulpotomy (excluding final 6.7 restoration)
(l) D3310 Endodontic treatment--one canal (excluding 20.0 final restoration)
D3320 Endodontic treatment--two canals (excluding 26.7 final restoration)
D3330 Endodontic treatment--three canals 27.6
(excluding final restoration)
(m) D3410 Apicoectomy (per tooth)-- first root 17.8
(n) D5110 Complete upper dentures 52.9
D5120 Complete lower dentures 67.5
(o) D5211 Upper partial--acrylic base (including any 22.0
conventional clasps and rests)
D5213 Upper partial--predominantly base cast 55.8
base with acrylic saddles (including any conventional clasps and rests)
(p) D5640 Replace broken teeth--per tooth 4.7
(q) D5820 Temporary partial--stayplate denture (upper) 20.6
(r) D6210 Pontic--cast high noble metal 52.1
D6240 Pontic--porcelain fused to high noble metal 38.9
D6241 Pontic--porcelain fused to predominately 37.0 base metal
D6242 Pontic--porcelain fused to noble metal 41.1
D6251 Pontic--resin with predominantly base metal 48.4
(s) D6750 Bridge retainers--crown--porcelain fused 38.9 to high noble metal
D6751 Bridge retainers--crown--porcelain fused 37.0
to predominantly base metal
D6752 Bridge retainers--crown--porcelain fused 41.1 to noble metal
(t) D7110 Single tooth extraction 4.7
D7120 Each additional tooth extraction 4.1
(u) D7210 Surgical removal of erupted tooth requiring 9.0
elevation of muco-periosteal flap and removal of bone and/or section of tooth
D7250 Surgical removal of residual tooth 7.8 roots (cutting procedure)
(v) D7880 Occlusal orthotic appliance 33.5
(w) D8999 Unspecified orthodontic procedure BR
(x) D9110 Palliative (emergency) treatment of dental 2.4
pain--minor procedures
(y) D9220 General anesthesia 14.5
(z) D9951 Occlusal adjustment--limited 3.8
D9952 Occlusal adjustment--complete 5.9
D9961 Special reports such as insurance forms, or BR
the review of dental data to clarify a patient's status--more than information conveyed in the usual reports.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1561 PHYSICIAN FEES -- MEDICINE FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) For services provided from April 1, 1993, through December 30, 2007, fees for medicine specialty area services are payable according to the values listed in Relative Values for Physicians.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for each medical specialty area service performed by a doctor of medicine, doctor of osteopathy, and doctor of podiatry are as follows:

Specialty Procedure Conversion
Area Codes Factor
(i) Medicine 90000 - 99999 $ 3.77
(ii) Surgery 10000 - 69999 80.55
(iii) Radiology 70000 - 79999
(Professional or Total Component) 15.59
(iv) Pathology 80000 - 89999 13.50

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1566 PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

(1) For services provided from April 1, 1993, through December 31, 2007, except as otherwise provided by this rule, fees for the anesthesia medical specialty area are payable according to the values listed in Relative Values for Physicians. Special unit value rules listed in (4) and (5) are established for anesthesia. Those special unit value rules supersede the corresponding unit values listed in Relative Values for Physicians, and apply to all providers. A physician who furnishes other medical services in addition to anesthesia must use the fee schedule that applies to the services rendered.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for anesthesia specialty area services is $28.97.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) Time values for anesthesia specialty area services are calculated according to the Value Guidelines given at the beginning of the RVP Surgery/Anesthesia section, except the extra minutes after multiples of 15 (or 10) may be assigned fractions of a whole unit. For example, a total anesthesia time of 2 hours 20 minutes would have a prorated unit value of 9.3 (9 units for the first 2 hours 15 minutes, and .3 units for the remaining 5 minutes).

(5) Fees for the following anesthesia specialty area services are calculated using basic values only and the addition of time units is not allowed:

(a) Pulmonary Function Testing, procedure codes 94000 through 94799.

(b) Therapeutic and diagnostic services, including nerve blocks, which includes the following codes: 20550, 31500, 36400, 36420, 36425, 36488, 36489, 36490, 36491, 36600, 36620, 36625, 36660, 62270, 62273, 62274, 62276, 62277, 62278, 62279, 62280, 62282, 62288, 62289, 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64417, 64418, 64420, 64421, 66425, 64430, 64435, 64440, 64441, 64445, 64450, 64505, 64508, 64510, 64520, 64530, 64600, 64605, 64610, 64620, 64630, 64640, 64680, 92960, 93503, and any other procedure codes that RVP identifies as "not appropriate for time units".

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1572 CHIROPRACTIC FEES FOR SERVICES PROVIDED FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) Effective July 1, 2002, through December 31, 2007, fees for services rendered by doctors of chiropractic are payable only for the procedure codes listed below and unless otherwise specified, are payable according to the unit values listed in the RVP. The procedure codes, descriptions, and unit values in the RVP apply to diagnostic x-rays for services provided by doctors of chiropractic.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) Except as provided by (6), the conversion factor used depends on the date the service was rendered:

(a) Effective July 1, 2002, the conversion factor for services performed by a doctor of chiropractic (other than diagnostic x-rays) within their scope of practice is set at $4.25 for services provided under (4)(a) and (b) below.

(b) Effective July 1, 2002, the conversion factor for services performed by a doctor of chiropractic (other than diagnostic x-rays) within their scope of practice is set at $4.25 for services provided under (4)(c) and (d) below.

(c) Effective July 1, 2002, the conversion factor for diagnostic x-rays performed by a doctor of chiropractic is set at $20.23.

(d) Beginning January 1, 2003, the conversion factor will be adjusted in the manner specified by ARM 24.29.1536.

(4) Only the following codes found in the RVP may be billed for chiropractic services:

(a) All physical medicine and rehabilitation codes except 97001 through 97006, 97033, and 97770 through 97781. Code 97799 may be billed only for providing the following services and requires a separate written report describing the service provided when billing for this code:

(i) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(ii) a report associated with nonphysician conferences required by the payor; or

(iii) completion of a job description or job analysis form requested by the payor.

(b) Special services, procedures and report codes 99070 and 99080. A separate written report must be submitted describing the service provided when billing for these codes.

(c) Chiropractic manipulative treatment codes 98940 through 98943.

(d) Evaluation and management codes 99201 through 99204 and 99211 through 99214.

(e) All diagnostic x-ray codes. The provider must furnish to the insurer documentation of the reasons justifying the use of the diagnostic x-ray procedure(s) employed.

(5) The explanations, protocols, comments and directions for use contained in both the CPT manual and the RVP to be applied to the procedure codes contained in this rule.

(6) Effective July 1, 2002, code 97750 is payable at $26.50 per 15-minute unit for a maximum of 24 15-minute increments of service per day. Beginning January 1, 2003, and each year annually thereafter, the amount payable per 15-minute unit for code 97750 shall increase by the percentage increase in the state's annual average weekly wage. If for any year the state's average weekly wage does not increase, the rate will be held at the existing level until there is a net increase in the state's average weekly wage.

(7) When chiropractors are performing orthotics fitting and training (code 97504) or checking for orthotic/prosthetic use (code 97703), supplies and materials provided may be billed separately for each visit using CPT code 99070.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1573 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR CHIROPRACTIC SERVICES PROVIDED FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) This rule applies to services provided from July 1, 2002, through December 31, 2007.

(2) Evaluations and re-evaluations may not be billed more than once every 30 days without prior authorization. For the first visit and for each 30-day evaluation, the chiropractor may charge for an office call in addition to treatment codes. For all other visits, the provider may charge only treatment codes without prior authorization.

(3) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750. Procedure code 97750 will be reimbursed at the rate specified in ARM 24.29.1572(6).

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical relative value has not been established, require prior authorization from the insurer.

(4) No more than two 15-minute units per day may be billed for each CPT code 97032, 97034, and 97035 without prior authorization. When ultrasound (CPT code 97035) and electrical stimulation (CPT code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(5) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(6) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(7) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(8) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(9) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(10) When billing for a manipulative treatment using codes 98940, 98941, 98942, or 98943, no office visit may be charged unless a modifier 25 is used for a specific evaluation and management code without prior authorization.

(11) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the chiropractor's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(12) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of a chiropractor. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(13) See ARM 24.29.1517 for additional prior authorization requirements concerning medical services provided by chiropractors.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1582 PROVIDER FEES -- OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM JULY 1, 2002 THROUGH SEPTEMBER 30, 2003 (1) Effective July 1, 2002, through September 30, 2003, fees for services provided by occupational therapists and physical therapists are payable only for the procedure codes listed below and unless otherwise specified, are payable according to the unit values listed in the RVP.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) Except as provided by (6), the conversion factor used depends on the date the service was rendered:

(a) Effective July 1, 2002, the conversion factor for services performed by a licensed occupational therapist, or a licensed physical therapist within their scope of practice is set at $4.25.

(b) Beginning January 1, 2003, the conversion factor will be adjusted in the manner specified by ARM 24.29.1536.

(4) Only the following codes found in the RVP may be billed for services provided by occupational therapists and physical therapists:

(a) All physical medicine and rehabilitation codes except 97033, and 97770 through 97781. Code 97033 may be billed only by physical therapists. Code 97799 may be billed only for providing the following services and requires a separate written report describing the service provided when billing for this code:

(i) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(ii) a report associated with nonphysician conferences required by the payor; or

(iii) completion of a job description or job analysis form requested by the payor.

(b) Special services, procedures and report codes 99070 and 99080. A separate written report must be submitted describing the service provided when billing for these codes.

(5) The explanations, protocols, comments and directions for use contained in both the CPT manual and the RVP are to be applied to the procedure codes contained in this rule.

(6) Effective July 1, 2002, code 97750 is payable at $26.50 per 15-minute unit for a maximum of 24 15-minute increments of service per day. Beginning January 1, 2003, and each year annually thereafter, the amount payable per 15-minute unit for code 97750 shall increase by the percentage increase in the state's annual average weekly wage. If for any year the state's average weekly wage does not increase, the rate will be held at the existing level until there is a net increase in the state's average weekly wage.

(7) When physical therapists are billing code 97033 (iontophoresis), medication charges and electrode charges will each be billed separately for each visit using CPT code 99070.

(8) When occupational therapists or physical therapists are performing orthotics fitting and training (code 97504) or checking for orthotic/prosthetic use (code 97703), supplies and materials provided may be billed separately for each visit using CPT code 99070.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1583 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED BY OCCUPATIONAL THERAPISTS AND PHYSICAL THERAPISTS FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) This rule applies to services provided from July 1, 2002, through December 31, 2007.

(2) Examinations and re-examinations may not be billed more than once every 30 days without prior authorization unless physician ordered. For the first visit and for each 30-day examination, the occupational therapist and physical therapist may charge for an office call in addition to treatment codes. For all other visits, the occupational therapist and physical therapist may charge only treatment codes without prior authorization. All examinations and re-examinations require a written report separate from the daily treatment note that reflects the claimant's functional status.

(3) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750. Procedure code 97750 will be reimbursed at the rate specified in ARM 24.29.1582(6).

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical relative value has not been established, require prior authorization from the insurer.

(4) No more than two 15-minute units per day may be billed for each CPT code 97032, 97034, and 97035 without prior authorization. When ultrasound (CPT code 97035) and electrical stimulation (CPT code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(5) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(6) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(7) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(8) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(9) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(10) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the therapist's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(11) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of the treating therapist. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(12) See ARM 24.29.1517 for additional prior authorization requirements concerning medical services provided by chiropractors, occupational therapists, and physical therapists.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1584 PROVIDER FEES -- OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM OCTOBER 1, 2003, THROUGH DECEMBER 31, 2007 (1) Fees for services provided by occupational therapists and physical therapists from October 1, 2003, through December 31, 2007, are payable only for the procedure codes listed below, and unless otherwise specified are payable according to the unit values listed in the RVP.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit services to those that can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) Except as provided by (6), the conversion factor used depends on the date the service was rendered:

(a) Effective July 1, 2002, the conversion factor for services performed by a licensed occupational therapist, or a licensed physical therapist within their scope of practice, is set at $4.25.

(b) Beginning January 1, 2003, the conversion factor will be adjusted in the manner specified by ARM 24.29.1536.

(4) Only the following codes found in the RVP may be billed for services provided by occupational therapists and physical therapists:

(a) All physical medicine and rehabilitation codes, except 97770 through 97781, may be billed. Code 97799 may be billed only for providing the following services and requires a separate written report describing the service provided when billing for this code:

(i) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(ii) a report associated with nonphysician conferences required by the payor; or

(iii) completion of a job description or job analysis form requested by the payor.

(b) Special services, procedures, and report codes 99070 and 99080. A separate written report must be submitted describing the service provided when billing for these codes.

(5) The explanations, protocols, comments, and directions for use contained in both the CPT manual and the RVP are to be applied to the procedure codes contained in this rule.

(6) Effective July 1, 2002, code 97750 is payable at $26.50 per 15-minute unit for a maximum of 24 15-minute increments of service per day. Beginning January 1, 2003, and each year annually thereafter, the amount payable per 15-minute unit for code 97750 shall increase by the percentage increase in the state's annual average weekly wage. If for any year the state's average weekly wage does not increase, the rate will be held at the existing level until there is a net increase in the state's average weekly wage.

(7) When physical or occupational therapists are billing code 97033 (iontophoresis), medication charges and electrode charges must each be billed separately for each visit using CPT code 99070.

(8) When occupational therapists or physical therapists are performing orthotics fitting and training (code 97504) or checking for orthotic/prosthetic use (code 97703), supplies and materials provided may be billed separately for each visit using CPT code 99070.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1427 HOSPITAL SERVICE RULES FOR CLAIMS ARISING ON OR AFTER JANUARY 1, 2008 (1) This rule applies to services provided on or after January 1, 2008.

(2) Any overall rate change adopted by a hospital shall be reported to the department on a department-approved form before the effective date of the rate change. The department may in its discretion conduct audits of any hospital's financial records to determine proper reporting of rate change filings.

(3) Insurers shall make timely payments of hospital bills. In cases where there is no dispute over liability the insurer shall, within 30 days of receipt of a hospital's charges, either pay the charges according to the rates established by these rules, or notify the hospital that additional information is requested, and specify that information. The insurer shall then pay the charges within 30 days of receipt of the requested information.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1522 MEDICAL EQUIPMENT AND SUPPLIES FOR DATES OF SERVICE ON OR AFTER JANUARY 1, 2008 (1) This rule applies to equipment and supplies provided on or after January 1, 2008.

(2) Except for prescription medicines as provided by ARM 24.29.1529, reimbursement for medical equipment and supplies dispensed through a medical provider is calculated by using the RVU listed in the RBRVS times the conversion

factor established in [NEW RULE IV] in effect on the date of service. If a RVU is not listed or if the RVU is listed as null, reimbursement is limited to a total amount that is determined by adding the cost of the item plus the freight cost plus the lesser of either $30.00 or 30 percent of the cost of the item. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(a) Copies of the instructions are available on the department web site at http://erd.dli.state.mt.us/wcregs/medreg.asp or may be obtained at no charge from the Montana Department of Labor and Industry, P.O. Box 8011, Helena, Montana 59604-8011.

(3) If a provider adds value to medical equipment or supplies (such as by complex assembly, modification, or special fabrication), then the provider may charge a reasonable fee for those services. Merely unpacking an item is not a "value-added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable.

(4) This rule does not apply to:

(a) health care facilities;

(b) pharmacies; or

(c) equipment supply houses that are not also health care providers.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1533 NONFACILITY FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) The department adopts the fee schedule provided by this rule to determine the reimbursement amounts for medical services provided by an individual provider at a nonfacility or facility furnished on or after January 1, 2008. An insurer is not obligated to pay more than the fee provided by the fee schedule for a service provided within the state of Montana. The fee schedule is comprised of the following elements:

(a) the HCPCS codes, including CPT codes, which are incorporated by reference, and discussed in greater detail in (3);

(b) the RVU given in the 2007 edition of the RBRVS, which is incorporated by reference, unless a relative value is otherwise specified in these rules;

(c) the publication "Montana Workers' Compensation Nonfacility Fee Schedule Instruction Set for 2008", September 2007 edition, which is incorporated by reference;

(d) the conversion factors established by the department in [NEW RULE IV];

(e) modifiers, as found in the instructions; and

(f) the Montana unique code, MT001, described in greater detail in (8).

(2) The conversion factors, the CPT codes, and the RVU used depends on the date the medical service, procedure, or supply is provided. The reimbursement amount is generally determined by finding the proper CPT code in the RBRVS then multiplying the RVU for that code by the conversion factor. For example, if the conversion factor is $5.00, and a procedure code has a unit value of 3.0, the most that the insurer is required to pay the provider for that procedure is $15.00.

(3) Unless a special code or description is otherwise provided by rule, pursuant to 39-71-704, MCA, the edition of the CPT publication in effect at the time

the medical service is furnished must be used to determine the proper procedure code.

(4) Instructions for the fee schedule are available on the department's web site, along with already calculated reimbursement amounts by CPT code. All the definitions, guidelines, RVUs, procedure codes, modifiers, and other explanations provided in the instructions affecting the determination of individual fees apply. A copy of the instructions is available on the department web site at http://erd.dli.state.mt.us/wcregs/medreg.asp or may be obtained at no charge from the Montana Department of Labor and Industry, P.O. Box 8011, Helena, Montana 59604-8011.

(5) The maximum fee that an insurer is required to pay for a particular procedure is listed on the department web site and was computed using the RVU in the total facility or nonfacility column of the RBRVS times the conversion factor, except as otherwise provided for in these rules.

(6) Each provider is to limit services to those which can be performed within the limits and restrictions of the provider's professional licensure. For nonlicensed providers, the insurer is not required to reimburse above the related CPT codes for appropriate services.

(7) RVUs have not been established in the RBRVS for CPT codes 99455 and 99456. The RVU established by the department for:

(a) code 99455 is 2.5 RVU; and

(b) code 99456 is 2.8 RVU.

(8) When billing the services listed below, the Montana unique code, MT001, must be used and a separate written report is required describing the services provided. The reimbursement rate for this code is 0.5 RVUs per 15 minutes. These requirements apply to the following services:

(a) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(b) a report associated with nonphysician conferences required by the payor; or

(c) completion of a job description or job analysis form requested by the payor.

(9) Where a procedure is not covered by these rules, the insurer must pay a reasonable fee, not to exceed the usual and customary fee charged by the provider to nonworkers' compensation patients unless the procedure is not allowed by these rules.

(10) Where a service is listed as "by report", the fee charged may not exceed the usual and customary fee charged by the provider to nonworkers' compensation patients.

(11) It is the responsibility of the provider to use the proper procedure, service, and supply codes on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment until proper coding of the services provided is received by the insurer.

(12) Copies of the RBRVS are available from the publisher. Ordering information may be obtained from the department at the address listed in (4).

Should this electronic version of the rules differ from the Secretary of State's official printed version, the printed version controls. These rules are posted here for convenience only until the Secretary of State posts the official version on its website. This version only includes rules that were amended or adopted in Issue 20, the October 25, 2007, edition of the Montana Register.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1538 CONVERSION FACTORS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 -- METHODOLOGY (1) This rule applies to services, supplies, and equipment provided on or after January 1, 2008.

(2) The conversion factors are established annually by the department pursuant to 39-71-704, MCA. The conversion factor for goods and services, other than anesthesia services:

(a) provided on or after January 1, 2008, is $63.45.

(3) The conversion factors are established annually by the department pursuant to 39-71-704, MCA. The conversion factor for anesthesia services:

(a) provided on or after January 1, 2008, is $57.20.

(4) The top five insurers or third-party administrators, ranked by premiums written in Montana providing group health insurance coverage through a group health plan as defined in 33-22-140, MCA, and who use the RBRVS to determine fees for covered services, must annually provide to the department their current standard conversion factors by July 1.

(5) The conversion factor amounts for nonfacility services are calculated using the average rates for medical services paid by the top five insurers or third-party administrators providing group health insurance via a group health plan in Montana, based upon the amount of premium for that category of insurance reported to the office of the Montana insurance commissioner. The term "group health plan" has the same meaning as provided by 33-22-140, MCA.

(a) The department annually surveys the top five insurers to collect information on the rates (the RBRVS conversion factors) paid during the current year for nonfacility health care services furnished in Montana.

(b) The department's conversion factors for the following year are set at 110% of the surveyed average.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1574 CHIROPRACTIC FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) This rule applies to services that are provided on or after January 1, 2008.

(2) Fees for services rendered by doctors of chiropractic are payable only for the procedure codes listed below and, unless otherwise specified, are payable according to the amounts allowed by the nonfacility fee schedule. The reimbursement rates referenced in the nonfacility fee schedule apply to diagnostic x-rays for services provided by doctors of chiropractic.

(3) Only the following codes may be billed for chiropractic services:

(a) all physical medicine and rehabilitation codes except:

(i) codes 97001 through 97006;

(ii) code 97033;

(iii) code 97532;

(iv) code 97533; and

(v) codes 97810 through 97814;

(b) special services, procedures, and report codes 99080, MT001, and HCPCS codes for supplies and materials. Code MT001 is described in ARM 24.29.1533. A separate written report must be submitted describing the service provided when billing for the codes identified in this subsection;

(c) chiropractic manipulative treatment codes 98940 through 98943;

(d) evaluation and management codes 99201 through 99204 and 99211 through 99214; and

(e) all diagnostic x-ray codes. The provider must furnish to the insurer documentation of the reasons justifying the use of the diagnostic x-ray procedure(s) employed.

(4) The explanations, protocols, comments, and directions for use contained in both the CPT manual and the nonfacility fee schedule are applied to the procedure codes contained in this rule.

(5) Code 97750 is payable for a maximum of 24 15-minute increments of service per day.

(6) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of a chiropractor. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(7) When a chiropractor is performing orthotics fitting and training (code 97760) or checking for orthotic/prosthetic use (code 97762), supplies and materials provided may be billed separately for each visit using the appropriate HCPCS code.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1575 CHIROPRACTIC -- PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

(1) This rule applies to services that are provided on or after January 1, 2008.

(2) Evaluations and re-evaluations may not be billed more than once every 30 days without prior authorization. For the first visit and for each 30-day evaluation, the chiropractor may charge for an office call in addition to treatment codes. For all other visits, the provider may charge only treatment codes without prior authorization.

(3) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750.

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical RVU has not been established, require prior authorization from the insurer.

(4) No more than two 15-minute units per day may be billed for each code 97032, 97034, and 97035 without prior authorization. When ultrasound (code 97035) and electrical stimulation (code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(5) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(6) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(7) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(8) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(9) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(10) When billing for a manipulative treatment using codes 98940, 98941, 98942, or 98943, an office visit may be charged for the treatment without prior authorization only if a modifier 25 is used for a specific evaluation and management code.

(11) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the chiropractor's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(12) See ARM 24.29.1517 for additional prior authorization requirements concerning health care services provided by chiropractors.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1585 OCCUPATIONAL AND PHYSICAL THERAPY FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

(1) This rule applies to services that are provided on or after January 1, 2008.

(2) Fees for services provided by occupational therapists and physical therapists are payable only for the procedure codes listed below and, unless otherwise specified, are payable according to the amounts allowed by the nonfacility fee schedule.

(3) Only the following codes found in the nonfacility fee schedule may be billed for services provided by occupational therapists and physical therapists:

(a) all physical medicine and rehabilitation codes, except:

(i) 97532;

(ii) 97533; and

(iii) 97810 through 97814; and

(b) special services, procedures, and report codes 99080, MT001, and HCPCS codes for supplies and materials. Code MT001 is described in ARM 24.29.1533. A separate written report must be submitted describing the service provided when billing for the codes identified in this subsection.

(4) The explanations, protocols, comments, and directions for use contained in both the CPT manual and the nonfacility fee schedule are to be applied to the procedure codes contained in this rule.

(5) When billing code 97033 (iontophoresis), medication charges and electrode charges must each be billed separately for each visit using HCPCS codes.

(6) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of the treating therapist. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(7) When an occupational therapist or a physical therapist is performing orthotics fitting and training (code 97760) or checking for orthotic/prosthetic use (code 97762), supplies and materials provided may be billed separately for each visit using the appropriate HCPCS code.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1586 OCCUPATIONAL AND PHYSICAL THERAPISTS -- PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) This rule applies to services that are provided on or after January 1, 2008.

(2) Examinations and re-examinations may not be billed more than once every 30 days without prior authorization unless physician ordered. For the first visit and for each 30-day examination, the occupational therapist and physical therapist may charge for an office call in addition to treatment codes. For all other visits, the occupational therapist and physical therapist may charge only treatment codes without prior authorization. All examinations and re-examinations require a written report separate from the daily treatment note that reflects the claimant's functional status.

(3) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750.

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical RVU has not been established, require prior authorization from the insurer.

(4) No more than two 15-minute units per day may be billed for each CPT code 97032, 97034, and 97035 without prior authorization. When ultrasound (CPT code 97035) and electrical stimulation (CPT code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(5) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(6) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(7) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(8) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(9) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(10) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the therapist's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(11) See ARM 24.29.1517 for additional prior authorization requirements concerning medical services provided by occupational therapists and physical therapists.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA